		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046011

Facility Name: Prairie Manor Nursing & Rehab Center

Address: 345 Dixie Hwy (Number) Chicago Heights (City) 60491 (Zip Code)

County: Cook

Telephone Number: (708) 754-7601 **Fax #** (708) 754-8904

IDPA ID Number: 810583511001

Date of Initial License for Current Owners: 12/01/02

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	146	Skilled (SNF)	146	53,436	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,436	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,408	7,757	12,214	45,379	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,408	7,757	12,214	45,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.92%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/02 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 11,491

Medicare Intermediary Administar Federal - Illinois

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	197,906	32,195	15,349	245,450		245,450	(4,076)	241,374			1
2	Food Purchase		173,859		173,859		173,859	883	174,742			2
3	Housekeeping	160,255	30,115		190,370		190,370	(4,141)	186,229			3
4	Laundry	42,220	22,509		64,729		64,729		64,729			4
5	Heat and Other Utilities			152,383	152,383		152,383	1,134	153,517			5
6	Maintenance	76,272	95	155,824	232,191		232,191	(17,397)	214,794			6
7	Other (specify):*							9,728	9,728			7
8	**TOTAL General Services**	476,653	258,773	323,556	1,058,982		1,058,982	(13,869)	1,045,113			8
	B. Health Care and Programs											
9	Medical Director			23,000	23,000		23,000		23,000			9
10	Nursing and Medical Records	1,945,948	75,456	129,408	2,150,812		2,150,812	4,858	2,155,670			10
10a	Therapy	102,238		125	102,363		102,363		102,363			10a
11	Activities	120,597	4,539		125,136		125,136		125,136			11
12	Social Services	109,830		2,765	112,595		112,595	8,157	120,752			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,022	5,022			15
16	**TOTAL Health Care and Programs**	2,278,613	79,995	155,298	2,513,906		2,513,906	18,037	2,531,943			16
	C. General Administration											
17	Administrative	75,957		4,723	80,680		80,680	10,334	91,014			17
18	Directors Fees											18
19	Professional Services			307,305	307,305		307,305	(210,074)	97,231			19
20	Dues, Fees, Subscriptions & Promotions			45,633	45,633		45,633	(22,867)	22,766			20
21	Clerical & General Office Expenses	82,188	16,795	197,937	296,920		296,920	(35,587)	261,333			21
22	Employee Benefits & Payroll Taxes			444,358	444,358		444,358	(14,034)	430,324			22
23	Inservice Training & Education											23
24	Travel and Seminar			591	591		591	3,024	3,615			24
25	Other Admin. Staff Transportation			2,321	2,321		2,321		2,321			25
26	Insurance-Prop.Liab.Malpractice			144,090	144,090		144,090	626	144,716			26
27	Other (specify):*							18,652	18,652			27
28	**TOTAL General Administration**	158,145	16,795	1,146,958	1,321,898		1,321,898	(249,927)	1,071,971			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,913,411	355,563	1,625,812	4,894,786		4,894,786	(245,759)	4,649,027			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center #0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			43,499	43,499		43,499	328,606	372,105			30
31	Amortization of Pre-Op. & Org.							46,734	46,734			31
32	Interest			12,039	12,039		12,039	341,301	353,340			32
33	Real Estate Taxes			482,866	482,866		482,866	1,401	484,267			33
34	Rent-Facility & Grounds			390,000	390,000		390,000	(386,397)	3,603			34
35	Rent-Equipment & Vehicles			6,338	6,338		6,338	1,361	7,699			35
36	Other (specify):*			6,484	6,484		6,484		6,484			36
37	**TOTAL Ownership**			941,226	941,226		941,226	333,006	1,274,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		483,740	1,401,961	1,885,701		1,885,701	(21,989)	1,863,712			39
40	Barber and Beauty Shops			11,091	11,091		11,091	(11,091)	(0)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,154	80,154		80,154		80,154			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		483,740	1,493,206	1,976,946		1,976,946	(33,080)	1,943,866			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,913,411	839,303	4,060,244	7,812,958		7,812,958	54,167	7,867,125			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,309)	30		9
10	Interest and Other Investment Income	(1,215)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(291)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,000)	21		24
25	Fund Raising, Advertising and Promotional	(9,882)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(103,316)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (216,013)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	270,180		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 270,180		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 54,167		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Prairie Manor Nursing & Rehab Center

IDF 0046011

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beautty Income	$ (11,091)	40	1
2	Other Income	(97)	21	2
3	Jury Duty	(52)	10	3
4	Capitalized R&M	(22,348)	06	4
5	Non-Allowable Expenses	(47,302)	21	5
6	Collection Expense	(515)	21	6
7	Bank Charges (Bldg Company)	(617)	21	7
8	Filing Fees (Bldg Company)	(250)	21	8
9	Non-Allowable Legal	(19,264)	19	9
10	COPE	(1,780)	20	10
11				11
12				12
13				13
14				14
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16				16
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96				96
97				97
98				98
99				99
100				100
101	Total	(103,316)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(6)	297		(2,620)	(1,747)				(4,076)	1
2	Food Purchase	(291)							1,174				883	2
3	Housekeeping				(4,141)								(4,141)	3
4	Laundry													4
5	Heat and Other Utilities					1,134							1,134	5
6	Maintenance	(22,348)			(305)	1,211		4,040	5				(17,397)	6
7	Other (specify):*						8,675	987	66				9,728	7
8	**TOTAL General Services**	(22,639)			(4,452)	2,642	8,675	2,407	(502)				(13,869)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)			(9,208)			14,118					4,858	10
10a	Therapy													10a
11	Activities													11
12	Social Services							8,157					8,157	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,763	3,259					5,022	15
16	**TOTAL Health Care and Programs**	(52)			(9,208)		1,763	25,534					18,037	16
	C. General Administration													
17	Administrative							10,302	32				10,334	17
18	Directors Fees													18
19	Professional Services	(19,264)				(190,813)			3				(210,074)	19
20	Fees, Subscriptions & Promotions	(11,662)				(11,207)			2				(22,867)	20
21	Clerical & General Office Expenses	(147,781)	867			11,063		100,206	58				(35,587)	21
22	Employee Benefits & Payroll Taxes			(594)	(53)		(13,387)						(14,034)	22
23	Inservice Training & Education													23
24	Travel and Seminar					3,010			14				3,024	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					614			12				626	26
27	Other (specify):*						2,618	16,034					18,652	27
28	**TOTAL General Administration**	(178,708)	867	(594)	(53)	(187,333)	(10,769)	126,542	121				(249,927)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(201,398)	867	(594)	(13,714)	(184,691)	(331)	154,483	(381)				(245,759)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(2,309)	317,795			11,245				1,875			328,606	30
31	Amortization of Pre-Op. & Org.		46,734										46,734	31
32	Interest	(1,215)	342,305						2	209			341,301	32
33	Real Estate Taxes					1,401							1,401	33
34	Rent-Facility & Grounds		(390,000)			3,536			67				(386,397)	34
35	Rent-Equipment & Vehicles					1,360			1				1,361	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(3,524)	316,834			17,542			70	2,084			333,006	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(17,841)				(268)	(3,880)			(21,989)	39
40	Barber and Beauty Shops	(11,091)											(11,091)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(11,091)			(17,841)				(268)	(3,880)			(33,080)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(216,013)	317,701	(594)	(31,555)	(167,149)	(331)	154,483	(579)	(1,796)			54,167	45

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 390,000			$	$ (390,000)	1
2	V	32	Interest	191			342,496	342,305	2
3	V	21	Bank Service Charges				617	617	3
4	V	21	Filing Fees				250	250	4
5	V	30	Depreciation Expense				317,795	317,795	5
6	V	31	Amortization Expense				46,734	46,734	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 390,191			$ 707,892	$ * 317,701	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 109,358	$ 109,358	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	109,952	CCS EMPLOYEE BENEFIT GROUP	100.00%		(109,952)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 109,952			$ 109,358	$ * (594)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 39	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 33	$ (6)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	27,910	XCEL MEDICAL SUPPLY, LLC	100.00%	23,769	(4,141)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	2,058	XCEL MEDICAL SUPPLY, LLC	100.00%	1,753	(305)	19
20	V	10	NURSING	62,068	XCEL MEDICAL SUPPLY, LLC	100.00%	52,859	(9,208)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	359	XCEL MEDICAL SUPPLY, LLC	100.00%	306	(53)	24
25	V	39	ANCILLARY	120,256	XCEL MEDICAL SUPPLY, LLC	100.00%	102,415	(17,841)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 212,690			$ 181,136	$ * (31,555)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 297	$ 297	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,134	1,134	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,211	1,211	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	196,920	Care Centers, Inc.	100.00%	6,107	(190,813)	20
21	V	20	Dues and Subscriptions	13,320	Care Centers, Inc.	100.00%	2,113	(11,207)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	11,063	11,063	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,010	3,010	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	614	614	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	11,245	11,245	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,401	1,401	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,536	3,536	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,360	1,360	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 210,240			$ 43,091	$ * (167,149)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 59,299	Care Centers, Inc.	100.00%	$ 59,299	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	8,675	8,675	16
17	V	10	Nursing Salary	9,186	Care Centers, Inc.	100.00%	9,186		17
18	V	10a	Rehab Salary	125	Care Centers, Inc.	100.00%	125		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	2,738	Care Centers, Inc.	100.00%	2,738		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,763	1,763	21
22	V	17	Administration Salary	2,025	Care Centers, Inc.	100.00%	2,025		22
23	V	21	Office Salary	15,871	Care Centers, Inc.	100.00%	15,871		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,618	2,618	24
25	V	22	Employee Benefits	13,387	Care Centers, Inc.	100.00%		(13,387)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,631			$ 102,300	$ * (331)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 5,328	Care Centers, Inc.	100.00%	$ 2,708	$ (2,620)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,040	4,040	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	987	987	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	14,118	14,118	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	8,157	8,157	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,259	3,259	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	10,302	10,302	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	100,206	100,206	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	16,034	16,034	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,328			$ 159,811	$ * 154,483	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 2,319	Care Centers, Inc. - Health Systems Division	100.00%	$ 124	$ (2,195)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,174	1,174	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	5	5	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	32	32	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	3	3	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	2	2	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	58	58	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	14	14	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	12	12	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	2	2	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	67	67	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	1	1	26
27	V	39	Ancillary Enteral Supplies	542	Care Centers, Inc. - Health Systems Division	100.00%	274	(268)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	448	448	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	66	66	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,861			$ 2,282	$ * (579)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 1,875	$ 1,875	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	209	209	16
17	V	39	Vent Reimbursement	3,880	Vent Lease, LLC.	100.00%		(3,880)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,880			$ 2,084	$ * (1,796)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.96	2.08%	Mgmt Fee	$ 2,698	17-03	1
2	Adam Vales	Owner	Administrative	11.00%	See Attached	0.71	1.78%	CCS Veba	737	22-07	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	3.00	5.45%	Alloc. CCI	1,848	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,283		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 109,358	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 109,358	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 33	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						23,769	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						1,753	5
6	10	NURSING	Direct Allocation						52,859	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						306	10
11	39	ANCILLARY	Direct Allocation						102,415	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 181,136	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	45,379	$ 297	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		45,379	1,134	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		45,379	1,211	3
4	10	Nursing	Patient Days	1,484,397	42			45,379		4
5	11	Activities	Patient Days	1,484,397	42			45,379		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		45,379	6,107	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		45,379	2,113	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		45,379	11,063	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		45,379	3,010	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		45,379	614	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		45,379	11,245	11
12	32	Interest	Patient Days	1,484,397	42			45,379		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		45,379	1,401	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		45,379	3,536	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		45,379	1,360	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 43,091	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		59,299	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			8,675	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		9,186	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		125	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		2,738	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			1,763	7
8	17	Administration Salary	Direct Cost			38,431	38,431		2,025	8
9	21	Office Salary	Direct Cost			525,935	525,935		15,871	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			2,618	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 102,300	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	45,379	2,708	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			45,379		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	45,379	4,040	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		45,379	987	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	45,379	14,118	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			45,379		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	45,379	8,157	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		45,379	3,259	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	45,379	10,302	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	45,379	100,206	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		45,379	16,034	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 159,811	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		2,861	124	1
2	02	Food	Billable Income	2,144,835		987,169		2,861	1,174	2
3	06	Maintenance	Billable Income	2,144,835		3,597		2,861	5	3
4	17	Administration	Billable Income	2,144,835		24,000		2,861	32	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		2,861	3	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		2,861	2	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		2,861	58	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		2,861	14	8
9	26	Insurance	Billable Income	2,144,835		9,262		2,861	12	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		2,861	2	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		2,861	67	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		2,861	1	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		2,861	274	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	2,861	448	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		2,861	66	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 2,282	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	3,880	$ 1,875	1
2	32	Interest	Direct Billing	620,670	29	33,493		3,880	209	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 2,084	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Choice		X	Mortgage			$	$ 4,865,000			$ 328,732	1
2	First Choice		X	Mortgage				186,000			13,764	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Daiwa		X	Line Of Credit				55,924			12,039	6
7	Allocated From Ventlease		X								209	7
8	See Supplemental Schedule										2	8
9	TOTAL Facility Related						$	$ 5,106,924			$ 354,746	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,406)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,406)	14
15	TOTALS (line 9+line14)						$	$ 5,106,924			$ 353,340	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	CCI Health Systems Alloc.		X				$	$			$ 2	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	396,623	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	430,420	2
3. Under or (over) accrual (line 2 minus line 1).	$	33,797	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	450,470	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	484,267	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002	444,062	11
2003	429,019	12

2004 Accrual: $429,019 X 1.05 = $450,470

Home Office Allocation: $1,401.3

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-17-131-007-0000	Long Term Care Property	$ 429,019.38	$ 429,019.38
2.	Care Centers Allocation	Home Office Allocation	$ 106,873.39	$ 1,401.30
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 535,892.77	$ 430,420.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 46,734
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 46,734
4. Dates Incurred: 12/01/02

Nature of Costs: Financing & Organization Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2002	$ 450,000	1
2	Allocated From 2201 Main			10,752	2
3	TOTALS			$ 460,752	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,650,000	122,915		122,915		281,967	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		41,479	1,703		1,703		3,538	68
69	Financial Statement Depreciation			43,499			(43,499)		69
70	TOTAL (lines 4 thru 69)		$ 4,691,479	$ 168,117		$ 124,618	$ (43,499)	$ 285,505	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,691,479	$ 168,117		$ 124,618	$ (43,499)	$ 285,505	1
2	Electrical Repairs	2003	5,460		20	273	273	455	2
3	Plumbing	2003	2,163		20	108	108	162	3
4	Painting Supplies	2003	1,318		20	66	66	88	4
5	Plumbing	2003	2,299		20	115	115	153	5
6	Painting	2003	922		20	46	46	58	6
7	Painting	2003	938		20	47	47	59	7
8	Electrical Work	2003	996		20	50	50	62	8
9	Generator Repair	2003	710		20	142	142	237	9
10	Tuckpointing	2003	950		20	190	190	285	10
11	Door Frames & Hinges	2003	1,580		20	316	316	474	11
12	Painting & Decorating	2003	658		20	33	33	36	12
13	Painting & Decorating	2003	1,043		20	52	52	57	13
14	Painting & Decorating	2003	745		20	37	37	40	14
15	Painting & Decorating	2003	862		20	43	43	47	15
16	Painting & Decorating	2003	917		20	46	46	50	16
17	Dialysis Room Construction	2004	12,155		20	608	608	608	17
18	Vinyl Flooring	2004	20,559		20	1,371	1,371	1,371	18
19	Install New Phone Line	2004	842		20	77	77	77	19
20	Hvac Work	2004	1,211		20	202	202	202	20
21	New Windows	2004	558		20	93	93	93	21
22	Svc On Fire Alarm System	2004	953		20	113	113	113	22
23	Roof Repairs	2004	4,800		20	180	180	180	23
24	Elevator Service	2004	5,910		20	197	197	197	24
25	Install New Tile -1St Floor	2004	18,570		20	542	542	542	25
26	Install New Tile -3Rd Floor	2004	18,570		20	542	542	542	26
27	Replace Fire Doors	2004	10,400		20	303	303	303	27
28	Automatic Entrance Doors	2004	4,485		20	131	131	131	28
29	Generator Maintenance	2004	1,819		20	152	152	152	29
30	Remove Carpeting, Install Tile	2004	19,282		20	402	402	402	30
31	Window, Hardware, Tools	2004	3,799		20	79	79	79	31
32	Locking System And Keypads	2004	6,956		20	145	145	145	32
33	Electro-Mech Door Closer	2004	7,197		20	600	600	600	33
34	TOTAL (lines 1 thru 33)		$ 4,851,106	$ 168,117		$ 131,919	$ (36,198)	$ 293,505	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,851,106	$ 168,117		$ 131,919	$ (36,198)	$ 293,505	1
2	Analog Module Phone System	2004	7,698		20	513	513	513	2
3	Repair Pot Holes, Reseal	2004	5,025		20	84	84	84	3
4	Repair Generator	2004	2,525		20	42	42	42	4
5	Home Depot- Hardware	2004	3,892		20	49	49	49	5
6	Locking System And Keypads	2004	6,956		20	348	348	348	6
7	Casework And Tops	2004	6,570		20	82	82	82	7
8	Plastic Nameplates	2004	4,399		20	55	55	55	8
9	Heat Startup	2004	2,289		20	29	29	29	9
10	Construction On Room 346	2004	15,467		20	129	129	129	10
11	Carpeting For Admissions Office	2004	916		20	4	4	4	11
12	Bumpers For Resident Walls	2004	6,411		20	27	27	27	12
13	Double Egress Doors	2004	8,987		20	37	37	37	13
14	Single Door Replacement	2004	2,480		20	10	10	10	14
15	Replacement Valve	2004	2,683		20	134	134	134	15
16	Boiler Floor Switch	2004	1,064		20	49	49	49	16
17	Painting & Decorating	2004	2,194		20	73	73	73	17
18	Painting & Decorating	2004	2,789		20	93	93	93	18
19	Repair Leak Behind Dishwasher	2004	1,679		20	35	35	35	19
20	Painting & Decorating	2004	1,381		20	29	29	29	20
21	Painting & Decorating	2004	1,719		20	29	29	29	21
22	Painting & Decorating	2004	887		20	15	15	15	22
23	Painting & Decorating	2004	750		20	9	9	9	23
24	Painting & Decorating	2004	581		20	29	29	29	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,940,449	$ 168,117		$ 133,823	$ (34,294)	$ 295,409	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		2002		$ 4,550,000	$ 116,667	39	$ 116,667	$	$ 238,194	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prairie Manor Property LLC			2002	100,000	6,248	15	6,248		43,773	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,650,000	$ 122,915		$ 122,915	$	$ 281,967	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From 2201 Main		2002	2002	$ 14,816	$ 370	35	$ 370	$	$ 926	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From 2201 Main			2002	12,239	612	20	612		1,530	9
10	Allocated From 2201 Main			2003	14,424	721	20	721		1,082	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 41,479	$ 1,703		$ 1,703	$	$ 3,538	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,280,077	$ 200,314	$ 204,130	$ 3,816	10	$ 956,730	71
72	Current Year Purchases	118,171	4,416	32,585	28,169	10	32,585	72
73	Fully Depreciated Assets	4,027				10	4,027	73
74								74
75	TOTALS	$ 1,402,275	$ 204,730	$ 236,715	$ 31,985		$ 993,342	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Prior Year Care Centers Alloc.	2003	$ 20,881	$ 1,518	$ 1,518	$	5	$ 17,584	76
77		Current Year Care Centers Alloc	2004	319	48	48		5	48	77
78										78
79										79
80	TOTALS			$ 21,200	$ 1,566	$ 1,566	$		$ 17,632	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,824,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 374,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 372,104	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,309)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,306,383	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated From Care Centers				3,536			5
6	Allocated From CCI Health Systems				67			6
7	TOTAL				$ 3,603 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,699 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 685,304	$		$ 685,304	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,620			17,620	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			665,692			665,692	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				307,145		307,145	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					33,345	176,595		209,940	13
14	TOTAL			$		$ 1,401,961	$ 483,740		$ 1,885,701	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,234	$ 89,644	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,597,338	2,597,338	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	191,340	191,340	6
7	Other Prepaid Expenses	29,396	29,396	7
8	Accounts Receivable (owners or related parties)	463,393	49,301	8
9	Other(specify): See Attached Schedule	58,456	173,869	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,345,157	$ 3,130,888	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,550,000	14
15	Leasehold Improvements, at Historical Cost	192,597	292,597	15
16	Equipment, at Historical Cost	156,787	1,356,787	16
17	Accumulated Depreciation (book methods)	(52,597)	(1,242,245)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		39,968	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(14,304)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 296,787	$ 5,432,803	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,641,944	$ 8,563,691	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,700,752	$ 1,700,752	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	55,924	55,924	29
30	Accrued Salaries Payable	177,297	177,297	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,504	5,504	31
32	Accrued Real Estate Taxes(Sch.IX-B)	450,470	450,470	32
33	Accrued Interest Payable		26,123	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	381,943	1,343,494	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,771,890	$ 3,759,564	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,051,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,051,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,771,890	$ 8,810,564	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 870,054	$ (246,873)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,641,944	$ 8,563,691	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (35,286)	1	
2	Restatements (describe):		2	
3	See Attached	(49,526)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (84,812)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	954,866	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 954,866	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 870,054	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,517,003	1
2	Discounts and Allowances for all Levels	(4,838,074)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,678,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,151,763	6
7	Oxygen	3,125	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,154,888	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,894	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	318,660	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,306	19
20	Radiology and X-Ray		20
21	Other Medical Services	553,914	21
22	Laundry	14,869	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 932,643	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,215	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,215	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	149	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 149	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,767,824	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,058,982	31
32	Health Care	2,513,906	32
33	General Administration	1,321,898	33
	B. Capital Expense		
34	Ownership	941,226	34
	C. Ancillary Expense		
35	Special Cost Centers	1,896,792	35
36	Provider Participation Fee	80,154	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,812,958	40
41	**Income before Income Taxes (line 30 minus line 40)****	954,866	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 954,866	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Finished **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,587	1,683	$ 56,555	$ 33.60	1
2	Assistant Director of Nursing	1,817	2,015	51,284	25.45	2
3	Registered Nurses	14,774	16,633	420,292	25.27	3
4	Licensed Practical Nurses	24,405	27,658	553,274	20.00	4
5	Nurse Aides & Orderlies	88,718	99,748	838,974	8.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,687	7,626	102,238	13.41	8
9	Activity Director	2,208	2,502	46,824	18.71	9
10	Activity Assistants	8,545	9,548	73,773	7.73	10
11	Social Service Workers	6,933	8,000	109,830	13.73	11
12	Dietician					12
13	Food Service Supervisor	1,976	2,085	32,123	15.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,528	20,151	165,783	8.23	15
16	Dishwashers					16
17	Maintenance Workers	6,350	6,866	76,272	11.11	17
18	Housekeepers	19,370	22,544	160,255	7.11	18
19	Laundry	5,537	6,608	42,220	6.39	19
20	Administrator	2,080	2,207	75,957	34.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,901	6,303	82,188	13.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,843	2,213	25,569	11.55	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	216,259	244,390	$ 2,913,411 *	$ 11.92	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	228	$ 10,021	01-03	35
36	Medical Director	Monthly	23,000	09-03	36
37	Medical Records Consultant	18	720	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,527	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	312	27	12-03	45
46	Other(specify)				46
47	CCI Consultants	See Attached	17,377	13548	47
48					48
49	TOTAL (lines 35 - 48)	558	$ 53,672		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	643	$ 31,136	10-03	50
51	Licensed Practical Nurses	2,623	85,839	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,266	$ 116,975		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kay Ross	Administrator	0	$ 75,957
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,957

B. Administrative - Other

Description	Amount
Administrative Payroll Allocated From Care Centers	$ 2,025
Management Fees - Eric Rothner	2,698
TOTAL (agree to Schedule V, line 17, col. 3)	$ 4,723
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting Fees	$ 33,000
Care Centers, Inc	Legal Fees	13,320
Kaye Scholer LLP	Legal Fees	10,972
Neal, Gerber & Eisenberg LLP	Legal Fees	4,562
Meyer Magence	Legal Fees	5,082
Winston & Strawn	Legal Fees	8,292
Michael Z. Margolies	Legal Fees	1,173
Care Centers, Inc	Computer Services	5,256
ADP	Payroll Services	8,144
IIT/Sourcetech	Computer Services	780
Scantron Services Group	Computer Services	130
See Supplemetal Schedule		216,594
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 307,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,691
Unemployment Compensation Insurance	58,223
FICA Taxes	211,476
Employee Health Insurance	78,702
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	975
Other Employee Welfare	3,800
Holiday Expense	4,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 430,324

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,085
Advertising: Employee Recruitment	9,546
Health Care Worker Background Check	
(Indicate # of checks performed 55)	1,044
ILCLTC	5,210
Dues & Subscriptions	887
Licenes & Fees	880
Allocated From Care Centers	2,113
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,765

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	591
Allocated From Care Centers	3,010
Allocated From CCI Health Systems	14
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,615

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center **#** 0046011 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILCLTC $6990.48**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **No**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,554** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **80,154**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.